



Application for

HIV/AIDS Certified Licensed Vocational/Practical Nurse (ACLPN)

Candidate Information. Please print clearly.

First Name _____ Middle Initial _____

Last Name _____ Suffix _____

Preferred Pronouns _____

Address _____

City _____ State _____ Postal Code _____ Country _____

Email Address _____

Primary Phone _____ Alternate Phone _____

Current LPN/LVN License Number _____ License State _____ Expiration Date _____

Eligibility and Background Information. Choose only one answer for each question unless otherwise directed.

A. Percent of Working Time Currently Spent in HIV/AIDS Nursing:

- ☐ Less than 25% ☐ 25-50% ☐ 51-75% ☐ More than 75%

B. Primary Position:

- | | | |
|---|---|---|
| <input type="radio"/> Clinical Nurse Specialist | <input type="radio"/> Consultant | <input type="radio"/> Counselor |
| <input type="radio"/> Director/Assistant Director | <input type="radio"/> Head Nurse/Manager | <input type="radio"/> Infection Control Practitioner |
| <input type="radio"/> LPN/LVN | <input type="radio"/> Nurse Educator/Faculty Member | <input type="radio"/> Nurse Practitioner |
| <input type="radio"/> Nurse Researcher | <input type="radio"/> Patient Educator | <input type="radio"/> Sales/Marketing Industry Nursing Representative |
| <input type="radio"/> Staff Nurse/Clinician | <input type="radio"/> Other | |

C. Area of Professional HIV/AIDS Emphasis:

- ☐ Adult ☐ Pediatrics ☐ Both Adult and Pediatrics

D. Primary Practice Setting:

- | | | |
|---|---|---|
| <input type="radio"/> Clinical Trial Group | <input type="radio"/> Community-Based Organization | <input type="radio"/> Family Planning/STD |
| <input type="radio"/> Forensic Setting (jail, prison) | <input type="radio"/> HIV Testing Center | <input type="radio"/> Home Care |
| <input type="radio"/> Hospice | <input type="radio"/> Inpatient: Community Hospital | <input type="radio"/> Inpatient: Non-teaching Hospital |
| <input type="radio"/> Inpatient: Teaching Hospital | <input type="radio"/> Inpatient: University Affiliated Hospital | <input type="radio"/> Long-term Care Facility |
| <input type="radio"/> Outpatient/Ambulatory | <input type="radio"/> Primary Prevention Program | <input type="radio"/> Private/Group Practice/Physician's Office |
| <input type="radio"/> Public/Community Health | <input type="radio"/> School of Nursing | <input type="radio"/> Substance Abuse Treatment Center |
| <input type="radio"/> Other | | |

E. Experience in HIV/AIDS Nursing:

- ☐ Less than 2 years ☐ 2 years ☐ 3-6 years ☐ 7-10 years ☐ More than 10 years

F. Employment Status:

- ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed

G. Primary Practice Location:

- | | | |
|-----------------------------|--------------------------------------|--|
| <input type="radio"/> Rural | <input type="radio"/> Suburban | <input type="radio"/> Urban (less than 1 million population) |
| <input type="radio"/> Mixed | <input type="radio"/> Not applicable | <input type="radio"/> Urban (more than 1 million population) |



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H. Highest Academic Level:

- | | | |
|---|---|--|
| <input type="radio"/> Associate Degree, Nursing | <input type="radio"/> Associate Degree, Other | <input type="radio"/> Baccalaureate, Nursing |
| <input type="radio"/> Baccalaureate, Other | <input type="radio"/> Diploma in Nursing | <input type="radio"/> Diploma/Certificate, Other |
| <input type="radio"/> Doctorate in Nursing | <input type="radio"/> Doctorate, Other | <input type="radio"/> LPN/LVN Certificate |
| <input type="radio"/> Master's in Nursing | <input type="radio"/> Master's Degree, Other | <input type="radio"/> Other _____ |

I. Other Certifications Held: (Choose all that apply)

- | | | | | |
|-----------------------------|------------------------------|----------------------------|-----------------------------------|---------------------------|
| <input type="radio"/> CCRN | <input type="radio"/> CEN | <input type="radio"/> CIC | <input type="radio"/> CRNH | <input type="radio"/> OCN |
| <input type="radio"/> RN, C | <input type="radio"/> RN, CS | <input type="radio"/> None | <input type="radio"/> Other _____ | |

J. Where Did You Hear About the Certification in HIV/AIDS Nursing Program? (Choose all that apply)

- | | | |
|--|------------------------------------|-------------------------------------|
| <input type="radio"/> ANAC Annual Conference | <input type="radio"/> ANAC Chapter | <input type="radio"/> ANAC Mailing |
| <input type="radio"/> Colleagues | <input type="radio"/> JANAC | <input type="radio"/> Other Journal |
| <input type="radio"/> Other _____ | | |

K. Are you currently a member of ANAC?

- | | | |
|--------------------------|---------------------------|--|
| <input type="radio"/> No | <input type="radio"/> Yes | <i>If yes, please indicate Membership Number _____</i> |
|--------------------------|---------------------------|--|

L. Are you currently or have you been certified in HIV/AIDS Nursing?

- | | | |
|--------------------------|---------------------------|--|
| <input type="radio"/> No | <input type="radio"/> Yes | <i>If yes, please supply certification expiration date _____</i> |
|--------------------------|---------------------------|--|

Optional Information

Race ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ Native American ☐ Other

Age Range ☐ Under 25 ☐ 25-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60+

Gender ☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer not to answer

Candidate Signature

I have read and understand the requirements for candidate eligibility I affirm that all statements given on this application are true and correct to the best of my knowledge and that the HANCB is hereby authorized to contact any organization or individual listed hereon to verify my education and licensure history.

Candidate Signature: _____ **Date:** _____



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Payment Options

Certification Fee: \$125

Payment can be made online via the [HANCB website](#).

Note you do not need to have a PayPal account – you can check out as a guest.

Alternatively, HANCB now utilizes the secured third-party platform BILL.com for invoicing and collecting payments.

You can be invoiced for your certification fee by providing the following information:

Name _____

Address _____

Phone Number _____

Email address for invoice _____

Email completed form to hancb@anacnet.org